

MDPB Meeting
April 20, 2005

Members In Attendance: Alfred Riel, Kevin Kendall, Paul Liebow, Jay Bradshaw, David Ettinger, Eliot Smith, Steve Diaz

Excused: Beth Collamore

Guests: David White, Joe Lahood, Rhonda Chase, Dan Palladino, Rick Petrie, Joanne LeBrun, Paul Marcolini, Dan Batsie, Rob Tarbox, Jim Caron, Jim McKenney, Jeff Regis, Norm Dinerman, Alan Azzara, John Bastin, Scott Latulippe, Kevin Marston, Marcus Day, Robin Overlock, Warren Taltz, Dwight Corning, Liz Delano, Sandy Stevens

- I. Minutes: Approved with motion by Kendall, second by McKelway—
unanimous approval
- II. Legislative update: LD 196 which addresses the Maine Care ambulance reimbursement rate had unanimous committee approval but is stalled on the floor must likely because of the fiscal note. Bradshaw also touched upon other LDs which can be forwarded if so desired. EM Star contracts to purchasing for facilitators who have been approached, but we still have not received a response from those approached. Three out of four of the chair positions have been identified (if they accept).
- III. Protocols: a work group came together to thoroughly review the protocols because some errors had been noted, and the diligence has proven successful. Thanks given for their work, but this will require a reprinting and the regional coordinators have asked for a July 1, 2005 live date. LeBrun voiced concern whether this was enough of a delay, so the other regional coordinators in attendance were polled. July 1 was OK by general consensus, so motion by Liebow, second by Kendall, and unanimous approval. The process which occurred seems to be effective, and we will convene a meeting for both debriefing and formalization of this new process (noted that this should be soon). Maine EMS will send out letters to ED Directors and Hospital Pharmacists regarding the change in the protocol effective date change to July 1, 2005. This may also be an opportunity to write an article regarding system improvement, and how to go forward and adapt with what we have learned. Also, may want to uniquely identify Education committee and Operations committee designees who are in attendance at each MDPB meeting. Identifying designees may help with the flow of information and communications in general. Also, this process raised some points that cannot be addressed completely at this point given the “11th hour” of the process, but should be carried to the next protocol revision process.
- IV. Go Box/Disaster Medicine: Bastin presented a joint project between EMS and the Bureau of Health and MEMA in an attempt to have medical providers trained and linked to Hazmat and/or Rapid Response Teams. We are proposing 25 boxes (pelican boxes, to be exact) that are stocked to treat 12 people each and have the following medications: Diazepam (autoinject), Mark

I kits, tetracaine eye drops, morgan lens, calcium gluconate gel, albuterol MDI, and sodium thiosulfate. The goal is to have these stored at key hospital locations for deployment to local teams that are either hazmat or rapid response. The education component and protocols for such paramedics would need to be delineated by the MDPB. This was an update.

- V. Aeromedical discussion: tabled til next month.
- VI. CPAP: Batsie presented the data to date with their study. Not yet 50 patients but close, no adverse outcomes, and this seems to help (He can provide attachments of exact numbers that were available in part to us). They are currently waiting to get to 50 patients to do the number crunching, and also will then use a comparative group to see if this is really helping. Motion by Kendall, with second by Liebow, to continue this for 6 more months and then return to us with a report of the study (including raw data and statistical analysis)—unanimous approval. Motion number 2 by McKelway with second by Liebow to allow them to add a municipal service to this study—unanimous approval. Batsie then requested a device approval—he has been asked to bring this to the MDPB so that we can vote upon this after a more formal presentation. And lastly, friendly amendment to allow the CPAP protocol to change with the protocol changes regarding medications in the prehospital arena—this change occurs July 1, 2005. If this is a successful protocol, may look to see if homeland security money could help pay for units for services in Maine.
- VII. OLMC/medical director competency: good discussion surrounding the document that was distributed. Goal of a short OLMC program which can be web-based so that all ED providers in the State of Maine having a working knowledge and skill to provide OLMC. Larger program of a 2 day course for service medical directors to cover the role of medical direction in EMS. Some suggestions made during the discussion (see attached document) and will begin with OLMC portion (Section I). Will look to JB at MMC to see if we can tap some help from the resident class, and help Diaz draft a grant proposal from ACEP (currently he has in his possession a chapter grant application and EMS grant application). Asked for volunteers for work groups to help with content, and from there, will look at other developed programs to see what we can take from them regarding objectives and educational materials. The work groups are as follows: Overview—LeBrun, McKelway, Chase; Rules, Requirements and Responsibilities (QI may fit here)—Petrie, Marcolini, Diaz; Communications—Kendall Lahood, Stevens; Protocols—Batsie, Palladino; Legal Issues (including diversion, sign-offs, etc.)—Liebow, Day, Marcolini, McKelway, McKenney, Azzara; and Dinerman has taught all components previously and is available to us as an overview and content expert. The reason not to take a canned program and just retrofit, is that we are apt to overlook something if the product is all done—as per past practice, we need to be sure our content fits the State of Maine.
- VIII. “How do we assure that EMS personnel are knowledgeable about the protocols?” queried Smith. This prompted much discussion and opinions as to

how we address this. Right now, no mechanism. The following options were discussed:

- a. Petrie to develop a web-based program for CEH that covers protocol updates.
- b. Some state have proactive/prospective certification, and can Maine adopt this?
- c. Mandate an every 3 year recertification.
- d. More emphasis on service medical director

The discussion ranged through the points listed above, and although we can speak to this a bit, the idea of mandatory and/or 3 year recertification is a question for a larger group. We would like to emphasize the service medical director, and we are starting this with our introduction of the OLMC program. The suggestion by Petrie to offer a web-based CEH program and develop a mechanism through this route was a motion by McKelway and second by Liebow with unanimous endorsement. Perhaps one of the ACEP grants would fall within this realm.

NEXT MEETING: May 18, 2005